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ABSTRACT

This paper discusses the rationale and implementation procedures for a cognitively oriented intervention program for parents of preschoolers aged 2-3 based in a pediatric clinic playroom. The manual outlines guidelines for establishing such a service starting with recruitment of clients, maintaining the program for parents, organizing the play area, and training the paraprofessional staff. Chapters include information on: operation of the parent education program, training procedures and materials, space requirements, organization of the pediatric playroom, selection of materials, playroom procedures, selection of staff, education of staff, education of the community, and the extension of the parent education program. (Author/SB)

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HOW TO SET UP AN EDUCATIONAL INTERVENTION PROGRAM IN A PEDIATRIC CLINIC PLAYROOM

PS 009030

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I. Introduction

The parent education program based in a pediatric clinic playroom evolved from the following conditions:

1. The child from the low income and/or welfare family, in contrast to his contemporaries from better economic backgrounds, tends to lag in acquiring reading and related cognitive skills.

2. Since the mother is the major influence upon the young child's performance one way to erradicate the deficit poor children show at school entrance would be to teach her to stimulate and support her child's intellectual growth.

3. The playrooms of pediatric clinics can serve as natural and productive settings for teaching parents how children learn by play.

Starting with the first day of life, the infant begins to both interact and react to his environment. The immediate family has primary contact with the growing infant. They shape his world and influence his acquisition of the cognitive skills that lead to learning. The active participation of the parents in the education of the child is necessary to allow the child to reach his full potential in the intellective, social and emotional spheres. By virtue of her intimate contact with the child, the mother or primary caretaker has the opportunity to foster physical and mental growth via natural interactive processes.

The first institutional contact for parents of young children is often related to their need for health care. Depending upon their economic status, this service is dispensed in a child health station, pediatric clinic or pediatrician's office. The program to be described took advantage of the captive audience of parents of young children waiting in the pediatric clinic as the first years of life are crucial to later intellectual development. It was assumed that parents who were concerned with the physical well being of their children would also be interested in learning how to foster mental growth.

By using the waiting time to teach parents about early learning, including teaching methods to use at home daily, the mother became aware of her role as teacher.

The clinic playroom was used as a base for the teaching program since play is the medium whereby children learn about the world. It was serendipitous to enlarge the role of the existing clinic playroom and use it as a base for a parent education program aimed at improving the intellectual performance of her children who came for medical care. A recreation program in the pediatric clinic provided supervised activities for waiting children and their siblings. It was seen primarily as a baby sitting facility. However, the service rendered was appreciated by the clientele as well as the clinic staff. The former were able to see the doctor without worrying about their other children while the latter appreciated the diminished noise, confusion, and accidents incurred by waiting children. In summary, the needs of the waiting children could be met while also providing a service for parents. In this way the pediatric clinic playroom became a laboratory for learning for both parents and children.

II. Parent Education Program

A. Why parent education?

1. Provide parents with alternative ways of dealing with children that are adaptable for various cultural groups.

2. Model a way of interacting verbally with a young child and show how the quality of behaviors, especially language, varies as a function of age.

3. Demonstrate how a variety of standard toys can be used as vehicle for verbal interactions that will enable the parents to present new ideas to the young child.

4. Emphasize the sequential process of cognitive growth as well as the need to be aware of individual differences.

5. Stress the importance of involving the parent early in the educational process.

6. Discuss how teaching methods developed in the program can be used when carrying out daily activities, e.g., shopping, cooking, bathing the child.

7. SHOW HOW LEARNING CAN BE FUN FOR BOTH THE PARENT AND THE CHILD.

B. Operation of the program

1. Rationale

We work directly with the parent or surrogate (including fathers, aunts, grandmothers), since she is the primary teacher who will transmit the information to the child. This method eliminates the triangle which can occur when a parent and staff member find themselves inadvertently competing for the child's attention. We have found this method to be effective since it emphasizes to the mother that she is indeed important in helping her child to learn.

The program is not expected to replace the natural interactive processes that are an integral part of family life. Rather, we attempt to provide parents with alternative ways of dealing with their children that can be

modified to suit the individual child. Parents of young children have similar concerns related to appropriate child rearing practices because of the rapid behavioral changes that occur in the early years. Program experiences provide participants with new modes of approaching their children.

The techniques used for teaching parents was role playing. As the educational background of the parents was mixed we did not want to rely on written materials. Further, we made no attempt to determine their literacy level as we thought this would be intrusive. However, a worksheet employing a pictorial outline of the exercise was given out at the end of each session. The explanation of the program to the parent at the initial contact and at subsequent appointments is described in detail in appropriate sections.

2. Recruitment procedures

a. Initial contact and interview. The curriculum was designed for children ages 2 and 3. Therefore, the program was open to parents of children ages 20-39 months. Interviewers contact all parents in the respective waiting areas, e.g., pediatric clinic, pediatric emergency room, and child health station. The explanation of the program given to the parent at first contact is listed in Appendix, page 46 To meet the needs of our population the interviewers were bilingual. We found that the playroom assistants could be trained to carry out the initial interview and handled this task very well. They were sensitive to the population and did not take rejections personally as did the interviewers brought in only for this phase of the program.

If the child is in the proper age group and the parent agrees to participate she is told that the child will undergo a developmental evaluation, which

she can attend, and she will also be asked to supply limited demographic information. The initial contact form is in Appendix , page 47.

We recommend that the initial interview and the evaluation be separated in time. Parents often agreed to participate in the program to please the interviewer and we found that a time lapse between the interview and evaluation permitted the parent to make a more independent judgment. Since the initial contact takes little time it permits the program to function more efficiently in terms of staff time and program planning. When the program is newly instituted one can expect a 50% attrition between interview and evaluation. This will change as the program becomes institutionalized and accepted as a service in the community.

For research purposes, the interview and evaluation were carried out at the initial point of contact for part of the sample. Thus, we were able to gain information on those parents who would drop out before the evaluation was given. No significant differences were found in the two groups (Morris, London & Glick, 1976). However, this approach demanded that testers be available when the recruitment procedures were carried out. It did not utilize staff as effectively as the separated approach described earlier.

b. Evaluation of the child. The primary purpose of the evaluation was to gain information about the level of performance of the children in the community. We were also concerned about early detection of children with organic and/or psychiatric problems. The program curriculum is designed for a normal population and damage' children require an individualized program to meet their particular needs. Although the program can be adapted for such children, and was when necessary, we felt that it would be important to pick

them up before they entered the program so that changes in treatment were not made after the fact. The latter could be discouraging both to the parent and the child. In addition, children who scored very low or were unable to perform at all were referred to the pediatric clinic for a complete evaluation. Such children were referred back to us if possible and those who required specialized training were referred to appropriate agencies.

We used the Cattell and the Stanford-Binet for the initial evaluation since we planned to follow the children over time. The evaluation proved to be a learning experience for the parents. Since it is often difficult and not advisable to separate the young child from his mother, the latter was often in attendance. In some instances, parents asked to remain in the waiting area and we respected their wishes.

The tester was bilingual and initially explained the testing procedure to the parent. She was told that we wanted to see how the child handles different materials and responds to instructions. Further, we wanted to know more about the children with whom we would be working and were not concerned with their passing or failing of the procedure. This was stressed repeatedly. Finally, we prepared parents for the fact that the children would be given items that were beyond their abilities and we would not expect them to do them properly but this was the only way we couldbring the test to an end. Parents seemed to feel that the testing procedure expressed our concern with their children and the majority accepted it as a positive experience. They were amazed and delighted to see their children respond positively to an adult and follow instructions appropriately. They felt that the evaluation was a learning experience for them as well as their children, and in a sense it prepared them for the individual instruction that was

was carried out in the home program. The children enjoyed the individual attention they received. The activities in the initial test were primarily perceptual-motor skills and they viewed them as play activities. We found that we often had to use lollipops to get the children to leave rather than as an incentive to perform because they enjoyed the testing session.

c. Assignment to program. Since we always had more parents interested than staff available we used an early/late assignment procedure that allowed all interested parents to enter the program at some point. The early group entered the program immediately and the late group started 6-8 months later.

Based on previous experience we expected about a 40-50% attrition rate between evaluation and induction to the program. Therefore, after 30-40 children were evaluated we matched them on age, sex and ethnicity and then randomly assigned them to either group. Although this method was required by the research design, it is recommended since it removes bias from program entry and unless a large staff is available realistic limits must be set up from the beginning. A letter was sent to parents in the late group telling them approximately when they would be contacted.

Depending on staff size and the response to the program, subjects in the late group can fill in as back-ups when the number of drop-outs is determined. In this way, each staff member can maintain a stable number of clients. Interviewing can be resumed when it is possible to offer the services to new clients.

Parent-child dyads were randomly assigned to a single trainer for the entire program. Language needs were the only mitigating factor in making

such assignments. We found this method to be equitable for both the clients and the staff.

3. Training procedure

a. Scheduling the first appointment. Initially, a letter is sent to the parent (see Appendix, page 43). The letter is brief and to the point. Letters sent to Spanish parents were bilingual since if they were illiterate they had to depend upon a neighbor or older child to read it. In this instance, English was the preferred language.

We refer to the program by location, that is, "the playroom program" since is was identified in this way by the parents rather than by its formal title, "Parent Education Program". If the letter was returned it was immediately established that the parent was unreachable unless they had given us a telephone number. This enabled one to fill in with parents in the late group.

For families with telephones the letter was always followed by a call to set up the initial appointment. Telephoning was more efficient and effective and parents said they preferred this method of contact. This proved to be an additional opportunity to explain the purpose of the program, specifically to reiterate that teaching is carried out in the clinic and is then transmitted by the parent to the child in the home. When the program began this was necessary as some parents were under the impression that we were running a day-care program. As the service became known in the community this additional explanation was not always needed.

Parents with and without telephones receive a letter after the appointment is scheduled. An appointment slip that is used in the particular clinic or

health station is enclosed. The parents were used to this system and usually brought in the appointment slip in order to make sure that they were in the right place. If the parent has a telephone, they are called as a reminder the morning of the appointment. This enables the staff to follow a schedule and parents are not kept waiting. All letters were sent out 3-4 days in advance of the first appointment since we found that if the letters were sent more than a week in advance the parents often forgot about the appointment.

A FIRST APPOINTMENT RECORD is included in the Appendix, page 49. We had hoped it would serve as a predictor for those who would remain in training. It can be used for those parents who miss the first appointment and keep a subsequent appointment. However, it was found that the initial impression was also recorded on the TRAINING SCHEDULE (See Appendix, pages 50-52). Therefore, when a new group was inducted into training the FIRST APPOINTMENT RECORD was used to monitor the intake and then discarded.

b. Maintaining contact throughout the program. At the end of each session the parent is given an appointment, at her convenience, using the clinic appointment slip. The appointment is then recorded on the DAILY APPOINTMENT SCHEDULE. (see Appendix, page 53). If the client can combine a medical appointment with one for the program this is preferable.

Letters or telephone reminders should continue throughout the program as needed. We found that some parents always keep their appointments on time while others have not developed the habit of keeping any scheduled appointments. Since the trainers worked part-time on two sites, it was preferable for the parent to attend at the stated appointment time so they could establish a

relationship with an individual trainer. Although the staff was interchangeable we found that parents preferred to work with one person. The additional efforts involved in the maintenance of appointments proved to be worthwhile since it provided for continuity of treatment, better attendance, and improved utilization of staff.

After each appointment the staff member records her impressions on the TRAINING SCHEDULE. This helps her to focus on what actually occurs during each session and to chart progress. The record is available to others if a staff member is away when her client arrives for an appointment. This enables other staff to select the materials needed and proceed with the training. The records are also reviewed during meetings of the director and individual trainers.

1. Carfare

Carfare was given to parents who used public transportation. Ideally, parents lived within walking distance of the clinic. However, open recruitment leads to enrollment of parents who lived outside the immediate area. Most of the parents using pediatric clinics or child health stations are on limited budgets while others may get public assistance. Since parents should come in every two weeks to maintain the pace of the curriculum we decided that those who came in only for the program would receive carfare. We feel that it is important to maintain the continuity of training and the carfare was a very small part of the budget.

2. Community priorities and their effect upon attendance

When setting up appointments the cultural and social obligations in the community should be considered. This includes the hours schools

open and close, holidays, etc. Parents in our community would take their older children to school and pick them up at lunch and after school because of their concern for their safety. As a result,they preferred to come in for the program during school hours so they will be available to pick up their children as needed. Special holidays celebrated within a particular community should be considered when planning the program schedule, e.g., in East Harlem, the Spanish community celebrated "Three Kings Day". Another date to be checked is when checks are sent out for families on ADC or welfare. Parents do not like to announce that they receive public assistance and their wishes should be respected. When we started to work in the clinics, we found that on certain days the waiting rooms were empty and few clients came in for medical treatments and for the program. We learned that these were the so-called "check days" and circumvented this problem by not scheduling appointments for training or evaluation on these days.

c. Introduction of the program to the parent

When the program begins, we emphasize that the parent is the first and most important teacher of the child. Next, that there are many ways to teach children. From our work in the playroom we have developed a variety of effective techniques for teaching young children through play activities. We want to share this information with parents since they have continuous contact with their children and we see the children for only short periods of time. Since he spends most of his time at home in his early years the home provides the opportunities for early instruction.

We then explain that we work with the parent rather than the child because the parent has a store of knowledge based on her past experiences that enables us to teach the method to her in a single session. Whereas, the

young child is in the process of learning about the world and has to have repeated experiences in order to learn new concepts.

The above leads naturally to a discussion of the differences in learning of adults vis a vis children. This is a particularly important part of the discussion. Many parents are unaware of these differences and become frustrated when a child does not remember what he has been taught after one session or when he becomes disinterested due to a short attention span. One analogy that we have found useful is the description of how the child learns to walk. At about one year of age, the child starts to take a few steps and falls, he gets up and walks again. Gradually the number of steps increases and shortly the child is walking upright all the time. This is similar to the operation that occurs in learning about colors or shapes. The child may follow instructions correctly the first time and at the next session forgets where to place objects. This is to be expected. Therefore, children need repeated experiences, just as in walking, to truly incorporate an idea and use it appropriately.

Again, we reiterate the need to involve the mother in the educational process and emphasize that we work with her since we have found this to be the best way of helping her child. She knows her child better than we do and can tailor the program to suit his needs. Also, she often knows how he will respond to various toys and what types of instruction will be most effective for him. The above reassures the parent and helps her to deal with normal inconsistencies of behavior by preparing her to expect them as part of growth.

d. Teaching method

The curriculum is made up of 12 structural exercises that concentrate on language and perceptual development while using problem solving strategies. Each exercise focuses on a primary feature of the toy (Parent Education Program Curriculum, 1972).

Role playing is used to impart information to the parent. We have found this method to be successful in teaching parents the training methods quickly and easily. Before starting you should also say that at the beginning of the program parents may feel awkward while going through the exercise. It helps to remind parents that the staff learns how to carry out the program in exactly the same way that we teach them. This makes role playing much more acceptable as a teaching device.

First, the trainer takes the role of teacher/mother and gives specific step-wise instructions to the mother who role-plays child. Later, the roles are reversed. The parent thus has the opportunity to be both child and teacher. While the staff member plays mother/teacher she reinforces the mother very heavily. The parents enjoy the praise. When the mother takes on the role of teacher the trainer responds the way a child might and makes mistakes, loses attention for a moment, or even starts doing something else. Throughout the mother's instruction session, the tutor encourages the mother's skills and responds warmly to her praise, again reinforcing the mother's positive behaviors.

When the trainer assumes the child's role she has the opportunity to point out that the teaching must be adapted to the child and his mood at a given time, and again reminds the parent that a child's behavior is never as consistent as that of an adult. So be prepared for surprises.

The staff member makes mistakes while the mother is teaching. In contrast

the parent responds correctly while learning the method. This allows us to point out again the differences between teaching an adult vis a vis a child. Next, one can stress that when a child does not remember the name of a color or places a block in the wrong hole it is an opportunity to teach. A mistake can lead to an important learning experience. It should not be seen as a negative but rather as another way to acquire information.

A very important part of the program is the modeling by the trainer of ways to interact verbally with the young child. Parents are often unaware of the need to use specific words when talking to the child. Many did not realize that they were a primary influence on language development. They derived enormous pleasure in seeing their children learn to label objects and describe their activities in words. The parent had an opportunity to see how the quality of language used varies as a function of age when role playing with age appropriate materials. For example, they learn that what may seem very repetitive to an adult is absolutely fascinating to a youngster who can repeat words or actions over and over again without becoming bored. In fact, this can become a game. They being to see from their program experiences that when the child is ready he will tie the word and concept together. This reinforces the importance of stimulation from the adults when the child is ready to acquire new ways of knowing his world.

When the trainer makes mistakes, while role playing child, she observes the parent's reaction. Does she use language or demonstration as a teaching device or does carry out the correct action without explanation to the child. In either instance, we emphasize that children learn by doing. In the case of the young child, experience in the world is gained by

playing. We mention that adults can become very frustrated when a child does not follow instructions. At this time we can suggest that perhaps a slightly different method of teaching may be helpful or the mother may demonstrate again just what it is she wants her child to do.

We repeatedly discuss the importance of reinforcing the child positively, either by word or by gesture, when he does something right. This is crucial since we know that behavior that is rewarded will be repeated. Therefore, parents must stop and think about what they do. They then decide if their actions and words help their children to learn to do things that will ultimately make life easier for both child and parent. For example, a child who only gets attention when he is bad quickly learns that this is the best way to get attention and simply repeats his behavior. We point out the need for adults to attend to good behaviors as a means of encouraging it to reoccur.

Finally, we suggest that the parent work with the child at the same time and in the same place daily. In our discussion of how to carry out the program at home we help the parent to select the best place in the house for the one-to-one session. Usually, it is carried out in the kitchen or on a coffee table in the living room. If there are older children, the session is scheduled when they are in school. In some families the mother likes to have the child work with her when the father can participate too. In addition, toys and books are put away and taken out only for training so that the child will look forward to the play period. If the child gets tired or cranky, the materials should be put away. It is best to work with him when he is rested and perhaps the time should be rescheduled. All of the above is discussed prior to or after the training period.

e. Parent-child observation. After the third exercise an observation of the mother teaching the child is scheduled. Ideally, this is

carried out in the home. The parent is more comfortable in her own domain and the child is more responsive to her in this setting. Outside of the home, he may try to manipulate the situation since she is clearly not in command. However, there were certain areas in our community that were dangerous and although the staff went out in pairs it was decided by the clients and the staff that this was not wise. In reviewing this issue, we felt that to go into some homes and not into others might create conflicts and therefore, carried out all observations in the clinic area. An examining room was used, rather than the playroom, to give the parent-child dyad maximum privacy.

Both the program supervisor (professional) and the trainer (para-professional) are present at the observation session. Initially, parents used the toy from the previous exercise since they felt comfortable working with familiar materials. However, in some instances children were bored and uncooperative with these materials since they were ready for new experiences. Depending upon the parent's wishes the toy from the last exercise or another toy similar to that used in the previous exercise is provided. In the latter instance, the parent can use the format learned in the previous exercise for teaching. For instance, if a puzzle is used for the third exercise a similar puzzle is given at the new observation so that the parent can use familiar teaching techniques with the new materials. Most parents preferred to use the more familiar toy but we found it helpful to have an available substitute when needed.

After the session is completed the child goes back to the playroom and the parent has the opportunity to tell the staff how she feels the program is working for her and can raise questions regarding procedures, problems, etc. The parent is always reinforced positively for behaviors that lead to learning benefits

for the child; she is also given suggestions that will help her to use materials and herself more effectively.

Later, a form is filled out jointly by the two staff members and filed in the parent's record (see Appendix, page 54). This is also an opportunity for the supervisor to work with the trainer on techniques that might aid the parent in providing her child with more support. The observation sessions were effectively used for in-service training and were discussed at subsequent staff meetings if it was felt that the material presented could benefit other members of the unit.

A second observation was scheduled at the parent's request since they found this to be a useful experience. It is held after the seventh session and only the para-professional is in attendance. The procedure described above is followed. Later, the trainer reviews the parent's progress with the supervisor and raises problems, e.g., regarding the parent's ability to transmit information and/or her way of working with her child, that may require special attention. If the trainer feels it is necessary the supervisor attends the second observation too.

f. Parents comments post-program. At the end of the program parents are asked to answer an open-ended questionnaire (see Appendix, page 55). It is given to the parent at the end of the eleventh session so she can think about it and brought back to be filled in, in conjunction with the trainer at the twelfth session. We found that we received limited information when the parents filled out the form alone. The parents were very flattered by our request for suggestions. We found that they gave an honest evaluation of the program and supplied useable ideas that were implemented, e.g., adding another

observation session.

g. Party-meeting. At the close of the program a party-meeting was held. The size of the play area in our clinic limited the number invited to 10-12 since for every dyad one could expect one or more additional family members. The room was appropriately decorated and party foods including soft drinks, cookies and potato chips were served. Favors for the children were given at the end of the party. This is an occasion to again reaffirm the importance of the parent-teacher. When everyone is gathered, the program director presents each parent with a corsage or boutinnaire (depending on the sex of the participant) which is pinned on by their trainer. At the suggestion of the playroom assistants diplomas were made up and also distributed at the ceremony. This documented evidence of their work with their children plus their own worth proved to be very important to the parents (see Appendix, p.56) for diploma. Initially, the professional staff was skeptical about giving out diplomas but we learned that they had great value to the parents in the community who had had limited evidence of achievement in their life experiences.

Although parents viewed this event primarily as a social occasion we planned to use it to get additional information about the program. We thought they might be more comfortable about expressing their views about the program in a peer group situation. Directly after the diplomas et al are presented the program director asks for their comments (bilingual) and suggestions to aid in planning for the future. We found that parents were more candid at the meeting than in individual sessions.

Finally, this event gives parents an opportunity to meet other adults in the

community. We learned from the party-meeting that the socialization that occurs as a side benefit of program participation was crucially important to the parents, many of whom felt isolated in the community. While they enjoyed learning to teach their children they also appreciated attention from an admired adult. In this instance the playroom assistant, whose interest and support led them to increase their efforts to utilize the training techniques. In addition, they looked forward to talking to other parents with children of similar ages who were dealing with similar problems. The party-meeting was seen as an important part of the program by adult participants as social events were infrequent for many parents. The attendance was consistently 60-70% in all kinds of weather.

4. Space requirements

It is advisable to work with parents in the playroom since young children are more comfortable if they can see their mother. If possible, use an area that is partially isolated from the ongoing play activities, e.g., a small table in the far corner of the playroom worked for us. However, if the play area is very small and gets crowded it is often necessary to use an examining room or adjacent office. The child can come along if he will not stay in the playroom. Space for preparation of materials, storage of of supplies, and maintainance of records is discussed in Section III.B.2.c.

Most parents in low income communities cannot afford baby sitters. It is a necessity for them to bring their children along whey they come to the hospital for training sessions. If the parent knows the child is cared for she is more comfortable and can concentrate on how to use the training materials. The noise and confusion that naturally occurs in the

play area did not disturb the parents. Most of them live in small apartments and a quiet isolated room is not part of their milieu.

5. Training materials

Parents are given toys and books used at the training sessions to enable them to work with the child at home. Economic considerations will determine if the materials can be given outright to the families or returned when the new materials are distributed. We made it a policy to allow parents to keep all paper toys, e.g., puzzles, small books, etc. Toys that could be washed were to be returned before new materials were furnished to the parents. Funding restrictions demanded that books costing more than $1.00 be returned. This led us to seek out books that cost less and were equally good for teaching as the larger, more expensive children's books. Many of the better pre-primers have been published in soft cover and we used these primarily.

We found that we could determine how the materials were used by observing the condition in which they were returned. In addition, toys that were not suitable because of breakage, lost parts, etc. could be readily assessed when returned to the clinic and more acceptable substitutes were found. Frequently, the trainers used the condition of the toys and books as a starting point in discussing methods of implementing the program more effectively, e.g., if books were left outside all day without supervision they were readily torn by young children until they had learned how to handle them appropriately. Thus, the return of play materials enabled the staff to help the parent in planning how to carry out the program at home.

III. Pediatric Clinic Playroom

A. Why should a cognitively oriented parent education program be based in a pediatric clinic playroom?

As discussed earlier, the clinic playroom serves waiting children and their siblings. However, it is also a highly visible demonstration of how play activities can lead to learning. The organization of the play area can be designed to introduce waiting parents to the basic premises of the parent education program. In this way it can also be used as an educational resource by the community.

The playroom is a necessary back-up to an educational program based outside the home for the following reasons. First, we found that the presence of the playroom led to an increase in the number of positive responses to program recruitment. Recruiters approached parents in the child health station before the playroom was set up. The response to their inquiries was largely negative. After the equipment arrived and the play area opened there was a sharp increase in program volunteers.

We discussed this finding with the staff and also questioned parent participants about their initial response to the recruiters. The goals of the program were unclear to the parents when only a verbal description of the service was given. A live demonstration of staff working with children who then carried out purposeful activities, rather than running around the waiting room, made it clear that teaching children how to play was worthwhile. Earlier they had not understood why we would want them to teach their children. Since many parents were also concerned about the high level of activity of young children they were relieved to see that with instruction from adults this energy could be chanelled into activities that

provided pleasure plus learning experiences. This was another incentive to enroll in the parent education program.

Second, most parents brought their children with them when they came in for the training. The latter are supervised while the mother works with her trainer without interference. Since the adult usually helps the child to get settled the trainer has a chance to observe how the parent handles the child prior to working with the parent. This information helps the trainer to adapt teaching methods to suit a particular dyad.

Third, the opportunity for waiting parents to see other adults participating in the program lead to requests for program participation without active recruitment. In addition, constant exposure of the teaching program to the public was/best way the way to disseminate information about this new service. Further, it required no special efforts on the part of the staff and was continuous.

Finally, the implicit teaching that occurs during the dialogue between staff and parents is an important side benefit of such a program. For example, while parents watched their children play the staff member points out that the behavior they see is expected for a particular age level and not "bad" or"hyperactive" as parents fear. This information reassures parents who often have no expectations of what constitutes normal behavior of children at different ages. This leads to questions about the parent education program as well as other available resources in the community. In this way the introduction of an educational intervention unit to a clinic playroom can enrich both aspects of the program.

B. Organization of the playroom

1. General considerations

The basic change required in incorporating an educational intervention program into a clinic playroom is a reorientation of the child centered staff. It is the staff that must acknowledge the parent and child as an integral unit to change the ambience of the setting. By accepting the parent as a primary figure to the young child the staff is able to work with and and through the parent for the child's benefit.

Next, the views of the community must be considered when selecting materials and equipment since this will determine who uses the play area. Generally, children come to the clinic dressed in their best clothing. For this reasons, parents are loathe to permit toddlers into the play area if paints and similar messy activities are availabile. We felt that it was important to include the younger children, ages 1 1/2 to 3. Therefore, we eliminated activities that would soil clothing and placed crayons and magic markers for older children on high shelves. These could not be reached by the little ones and the children played simply with accessible materials. This led to a marked increase in younger children using the area. The change in available play materials did not interfere with the childrens' enjoyment of the program rather it exposed them to new activities. Since the toys and games were acceptable to the parent they asked questions about where to buy them, leading to a natural interchange of information.

Parents learned many new things about play as they began to use the area as an educational resource. They were fascinated to find that toys were age-graded. It followed that certain toys were more effective for one age group than another. When parents observed the children's positive response to

the guidance of the playroom assistant they reported that they had thought it was enough to give a toy to the child. Now they saw that it was necessary to help him get started using it. Clearly, the activities in the play area reinforce the teaching in the parent education program.

2. Space requirements

a. The open playroom. Ideally, the play area should be within the waiting room. A separate room emphasizes the distance between the parents and the staff. The open play areas in the East Harlem Child Health Station and the Prenatal Clinic of the Mount Sinai Hospital are diagrammed on page of the Appendix. The open play area is most effective for carrying out both parts of the program. Further, it allows young children to maintain eye contact with the parent. Many find it difficult to separate and will not enter a playroom that is separated from the waiting room.

The opportunity to observe play activities led to socialization of parents with staff and other parents. Initially, parents would stand outside the area and look in. Later they would often join in the play activities with their children. In many instances this was the first time a parent would stand back and see the child as an individual in his own right. It was a way for parents to learn about children and often led to questions about the educational program. Further, the ambience of the setting and the chance to see that play has value for young children encouraged parents to volunteer for the program without active recruitment.

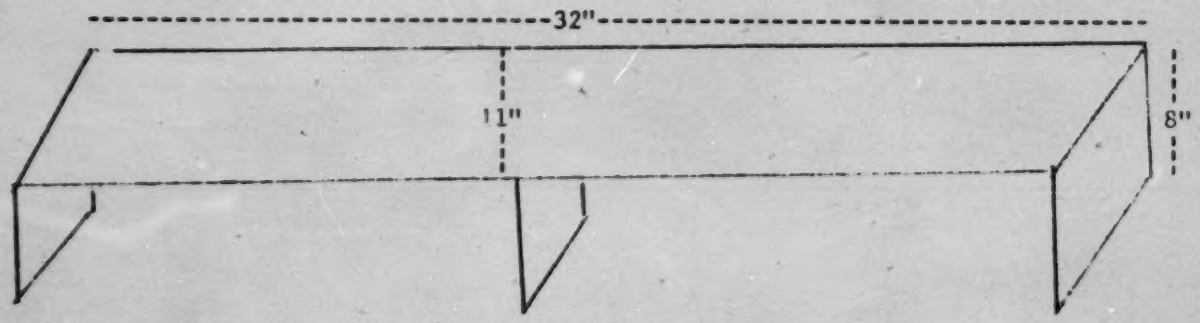
Finally, and equally important the open play area is part of the complete clinic program. The possibility of it becoming a domain restricted to the

playroom staff, which can occur in the separated playroom is lessened. The constant contact of staff with parents and other professionals sensitizes the former to the needs of the community and adjacent services. This permits the program to evolve and change rather than becoming static.

b. The separate playroom. If a separate room is the only space available it should be planned to be as accessible as possible for parents. It is necessary in this setting to constantly remind the staff to invite parents to come into the playroom in addition, to placing welcoming signs in the waiting area. Such a playroom, that can accommodate about 30 children, diagrammed on pages of the Appendix.

c. Space for storage, equipment, maintainance of records. If closet space is available than this should be used even if it is not located within the clinic. Materials needed daily can be brought over in the morning. A locked file drawer can be used to hold records. The play tables can also be used for preparing materials and recording notes during quiet periods.

Large locked steel cabinets were effective for storage. Most cupboards have only four shelves. To make them more functional the wooden shelves, shown below, were build to divide up the space. Play materials tend to be small and large deep shelves are space wasters.



3. Equipment

Standard playroom equipment can be obtained from stores that cater to nursery schools, Head Starts, etc. The toy chest used in the open playroom on page of the Appendix is ideal for an open area. It can be locked at the end of the day. Open toy shelves are used for the separated playroom.

The size of the play area determines the kinds of tables that will be selected. We found that round tables used up more space. Because space was an important consideration in our planning we selected rectangular and square tables. They could be placed against the wall for meetings and parties giving us extra space and were more adaptable in our setting.

Standard nursery school chairs were purchased. A word of warning about chairs follows. Be sure that they have a glider of some sort on the bottom of the legs. Most institutional floors are vinyl tile. Wooden chairs with no gliders make a harsh scraping sound. In the prenatal clinic we replaced some chairs because of complaints.

4. Selection and organization of play materials.

The ages of the children and the approximate numbers in each age group are primary considerations in selecting toys and games. This information can be obtained from the nursing staff and/or administration.

Choose toys that can be used in a variety of ways since the ages and number of children constantly changes. Manipulative toys, made up of many interchangable parts, proved to be most successful. Toys with many pieces can be used differently by children of various ages. For example, older children used a lego set to build objects while toddlers would sort the blocks into piles or

into containers when they were provided. Equally important, if a single part is lost the toy remains functional. This is essential in carrying out a program that has a constant turnover of children and a limited budget. We found mechanical toys limiting and did not use them. A list of toys and games is on pages in the Appendix.

The organization of the play area allowed children to select their own toys, with assistance from the staff, and then to work alone or with others as desired. All toys were placed in wicker trays so that the contents were easily visible. Small pictures of each toy were placed on the shelf below the tray so that the children could put them back before taking a new toy. Toys and games were age graded and placed in specific sections on the open shelves so they could be taken by children at various ages. For example, toys for toddlers, e.g., pop it beads, were placed on the lower shelves, while toys for preschoolers, e.g., lego, were on higher shelves in the toy chest. Games for older children plus craft materials were placed on high shelves out of the reach of younger children. Doll and house play was in a separate corner next to the dress up area; as was the reading corner.

As one observed the activities in the room it was clear that even young children could make decisions and follow through on an activity. This again demonstrated that play was a way of learning and organizing the world and not just a time waster. Parents asked many questions about the organization of the room and implied that they would try to set up something similar at home.

The entire staff, including professionals, washed all toys, trays, tables, etc. once a week. Wicker trays must be soaked periodically or else they become brittle and break. The clean-up period gives the staff a chance to check out

equipment and replace missing parts.

5. Playroom procedures

An outline used by staff and volunteers describing the playroom procedures is available in the Appendix, page . The following will deal with some of the nuances that were not included.

We found it necessary to continue to invite waiting parents into the play area, even after we had been there for over a year. There are always new clients in the clinic and one cannot assume that the full range of services is known to all. Initially, the staff found it difficult to approach strangers. However, reaching out to parents is an essential part of the service. Parents in poor communities will often wait for an invitation even if a welcome sign is placed over the door. Our willingness to approach parents, rather then waiting for them to come to us, was repaid many times by their appreciation of our understanding of their need for special attention.

When approaching a parent explain that the playroom is available for all waiting children. Be sure to invite both the parent and child into the playroom. If the parent does not want to leave the waiting room, ask her permission for the child to come with the staff member. Then, ask her for the name and age of the child. Write it on masking tape, and place the tape on his clothing.

This identifies the child and helps with selecting appropriate toys. It also makes the parent aware of our concern for the individual needs of each child. Children love the tapes and when they return come in and ask for their "name".

When the child enters he should be taken on a brief tour, depending on his age. We explain that only one toy at a time can be taken and that it should

be replaced before a new one is selected. The children adjust to this very quickly. On occasion a young child will take another's toy. He can usually be diverted by showing him another toy he can use. Sometimes younger siblings have been allowed to do this at home. We explain to parents that we do not feel this behavior is necessary in the playroom since we have plenty of toys. They find this explanation satisfactory and cooperate when a younger child becomes overly demanding of an older sibling.

The parent should be encouraged to ask questions and participate. They will ask where they can buy the toys used. We have information about local stores available.

We found that serving refreshments, e.g., milk and cookies, was a plus for the playroom. Many parents would not allow children to play for fear that they would get dirty or would not come when they were to see the doctor. When a staff member arrived with food they would be allowed to come in as food is a positive gesture in most cultures. In addition, we found that many children had missed a meal due to the appointment. The snack served to quiet hungry children who can become very restless.

IV. Selection

A. Program Director

1. Qualifications

a. The professional should have a family oriented background and expertise in child development as well as knowledge about health care. Disciplines with appropriate backgrounds are: occupational therapy speech therapy; special education; social work; early childhood education and public health or nurse practioner training.

b. A qualified applicant should have five years of clinical practice to carry out both aspects of the program and direct in-service training.

c. A flexible approach to program planning will allow the goals to be adjusted in response to the changing need of the population served.

d. The ability and interest to work directly with the clientele served must be stressed. Although administrative skills are required this is not primarily an administrative position; rather it involves clinical service and on the job teaching of staff fifty percent of the time.

2. Responsibilities

The professional is responsible for in-service education supervision of the para-professional staff in both the playroom and parent education program. The details are described in section IV.B.2.b.

She is a liason to other departments of the institution as well as community agencies. This involves attendance at meetings, participation in seminars and institutes and other activities relating to educating others about the services offered by the program. In conjunction with the staff she will set up goals to meet as well as guidelines describing the scope and limitations of the service program.

The program director should take a small number of parents through the complete curriculum during the first year of the program. This enables her to gain an

understanding of program implementation including nuances involved in training. It will also aid in adapting the program activities to a particular population. She is responsible for all administrative decisions including hiring and firing of staff; buying materials and equipment as needed; securing space to carry out the program; and planning educational programs such as workshops for community and interested professionals. She is also expected to prepare reports and publications to disseminate information about the program to professionals and lay persons.

B. Playroom assistant

1. Qualifications

A description of the qualities desired follows: Maturity, as demonstrated by a sense of responsibility toward the clientele and the institution. Initially, this can be assessed by an ability to keep appointments and to arrive at work on time. The playroom assistant should be self-motivated with a capacity to grow professionally. She should be able to use the in-service training to carry out her work independently with limited guidance from the professional. After a parent is assigned to a staff member she is wholly responsible for maintaining contact with her, writing notes and preparing materials for each session, as much of her work is carried out with no supervisor present.

Ideally, the staff should come from the community served. This means that playroom assistants will come into contact with parents with problems similar to her own. It is essential that each staff member be able to maintain a positive self-image under these circumstances rather than identify with problems to the detriment of her work. At meetings the staff often talked about the importance of leaving personal problems at the door and picking them up on the way home. We all felt that personal problems should never be brought into

the program since they interfere with primary service obligations. We found that parents with severe family problems were not effective in this program. They should be screened out at the initial interview, if possible.

The playroom assistant represents the program to members of the community. She must have qualities which allow her to be respected as a role model that parents want to emulate. As discussed earlier, the relationship of parent to trainer is crucial in program implementation. Age is not the prime criteria in selecting staff. Rather, maturity should be expressed in a sensitivity to the needs of others. In meeting these needs one must have the ability to work effectively with other disciplines in order to make appropriate referrals or seek help when needed. Finally, she must have had an educational background that will permit her to transmit the teaching methods of the curriculum and keep all necessary records.

The sex of the playroom assistant is determined by the mores of the community. We were advised by parents as well as staff from the community that a female would be more acceptable than a male to Hispanic families. Since our population was largely Hispanic this dictated our hiring practices.

When starting a new program one should consider community standards in terms of dress, behaviors and attitudes. This will vary from one community to another. Respect for the opinions of parents allows one to introduce the new service within the framework of accepted mores. For example, we found that our parents were more comfortable with staff members who wore identifying smocks and name tags rather than street clothes.

2. In-service training

a. Goals.

1. Understands premise of playroom program and parent education program from lectures and on-site training.

a. basics of child development, cognitive and affective.

b. how to relate to adults and children

2. Can accurately teach all exercises. Prepares materials in time for appointments and keepts records up to date.

3. Maintains confidentiality of familites and any records that are kept.

4. Perceptive to needs of population served. Responds appropriately to problems that may arise by referring parent to proper service if indicated.

b. Procedures. The preliminary training includes: 1) One month of supervision in the playroom program. During the first two weeks of this period the new staff member requires almost constant guidance. The latter part of the month she is introduced to the normal supervisory schedule which includes a brief meeting in the morning and another at the close of the day. She will continue to need direction during this time but is should be cut gradually to see how she can handle the work independently. 2) During the second week of the first month she can start observing the other staff members working with parents. By the third week she will start learning the curriculum. She begins by reading the material and progresses to memorizing the exercises and carrying them out alone and finally starts working with another staff member. It is most effective to study in blocks of time of 1 1/2 to 2 hours, at least three times a week. This continues for six to eight weeks. Ideally, this should be carried

out in a separate room or in quiet periods in the playroom. 3) At the beginning of the third month a limited number of parents (2-3) are assigned to the new staff member. The professional observes her during training sessions and provides her with feedback immediately after the training. 4) The preliminary training serves as a probationary period for incoming staff. The director should carefully assess her abilities to carry out the job responsibilities as well as her facility to work with other staff members.

In-service education for the clinic staff includes: 1) One hour weekly meetings for all staff members at which current and new activities are discussed. Each staff member has an opportunity to present problems or raise questions for discussion by the entire group. An agenda is distributed at the beginning of the meeting so that priority items are discussed. It also permits the director to set time limits to allow for discussion of new material at the end of the meeting. 2) Training exercises are demonstrated by the professional during preliminary training for new staff and as part of continuing staff education. 3) The director meets with each playroom assistant every two weeks to review individual case loads. If problems arise with a particular family the professional is available for consultation. Otherwise, problems are discussed at scheduled meetings. New staff members need additional meetings. These are usually held directly after observation of the training. 4) The professional continues to observe training sessions to monitor the staff's performance and insure that curriculum methods are followed. After a period of time we found that staff would either delete or add material to the training and needed reminders to maintain consistency. As mentioned earlier, in a clinic based intervention program, a client may turn up when her trainer is not available and then the teaching method is transmitted by another staff member. Under these

circumstances it is essential that the variability between teaching methods be kept to a minimum. 5) Conferences with other disciplines in the clinic and community agencies are scheduled to aid the staff in making appropriate referrals. The guest presents the goals of his program, e.g., social service, pediatric nursing, a local daycare center, and describes the range of services available.

3. How to anticipate and handle recurring problems

The list that follows covers the problems that came up repeatedly at staff meetings of the preliminary study at Bellevue Hospital, the pilot project at Mount Sinai Hospital and the research and demonstration project at both Mount Sinai Hospital and the East Harlem Child Health Station. Each project must deal with issues unique to its setting and its community. However, there are commonalities to share with you that may prepare you for dealing with problems that require constant monitoring and support.

a. A continuing discussion and reinterpretation of program goals is necessary for the staff to maintain effective teaching skills. They must always bear in mind that the primary aim of the training is to enable the parent to gain additional skills in teaching her child. The trainer must be flexible. Each parent approaches the program differently. Some gain skills slowly and may need to be more actively involved in the role playing sessions. The director should be called upon for assistance and suggestions for these clients. The staff must also remember that most parents are initially shy and may feel uncomfortable during role playing. This corresponds to the feelings of the staff when they were first introduced to the program. They should try to remember how they felt and perhaps share these feelings with the parent.

b. The director should deal immediately with complaints and problems. For example, if a staff member has a parent who will not follow the teaching methods arrange to sit in on the next training session. The presence of the program director can reinforce the teaching of the playroom assistant.

c. Be prepared to bolster up morale when new clients are assigned. The staff becomes discouraged when parents drop out and also when they miss appointments. Point out that this is not a personal thing, rather we expect about 50% to drop out and know that many parents have not learned to keep appointments regularly. Regarding the latter, the program has been planned so that parents who turn up for an appointment an hour or a day late can be seen by another staff member. It would appear that the playroom assistants evaluate themselves in terms of numbers of parents treated and appointments kept. In reviewing this data, it is clear that staff members who grow professionally had gains in both these areas. However, it is important for the staff to keep in mind that if a random assignment method is used it can lead to an unusually high drop our rate with a single group; over time this evens out.

d. There is always competition between staff members as to who has the most clients in the program. Make is clear that there is no contest underway. There are no winners based on the number of parents trained. Again, it is necessary to repeat that parents are randomly assigned. Some trainers will get interested parents by sheer luck. Another trainer may get parents who will drop out immediately or not come in at all. You will find that as trainers grow professionally they can predict which parents are truly interested and will ask for help earlier with those who may be problems. This indicates professional

maturity and can be used to evaluate performance.

e. Insist upon proper referrals to other units, e.g., social service. Many parents bring personal problems to their trainer which is very flattering. However, they have a specific job to do and have no time to deal with other issues. They should also realize that their training is specific to the program. Counselors have special training and can handle personal problems including marital problems, housing, etc.

f. Encourage an open discussion of problems. The weekly staff meeting should serve as a sounding board for anyone who wants to speak out. All staff members can benefit from the experiences, both good and bad, of their co-workers.

g. Remember that the parent education program is fun for parents as well as children. Mention good experiences as well as the bad ones. They occur just as frequently.

V. Additional considerations in starting a new program.

A. Education of the clinic staff

When an educational component is added to a playroom, it comes as a surprise not only to parents but to the clinic staff. The latter often sees the playroom as a dumping ground for noisy, active children who may interfere with their work. Meetings with individual clinic units are most effective in introducing the educational program. After the parent training begins it is valuable to invite staff members (with the permission of the parents) to observe training sessions. As they learned more about the program we found that other staff members would encourage parents to participate.

When one is adding both a playroom and a parent education program to an ongoing clinic service it is necessary to explain both aspects of the program to the clinic staff before the program starts. It is important to stress what is important to them as well as telling them how the program will serve the clientele. That is, the play area will curtail the noise and disruptive behavior that interferes with dispensing health care by providing supervised play activities for waiting children. It will also give parents additional tools for handling their children that will support their intellectual growth.

Our experience in the East Harlem Child Health Station and in the Prenatal Clinic of the Mount Sinai Hospital are quite possible typical of the responses to a new program. In spite of the pre-program orientation, resistance arose on both sites when the equipment was installed. It would seem that anything new becomes a threat to the existing system, especially

when it is physically present. Therefore, no matter how enthusiastic the staff mey be one can expect a normal resistance to change when the playroom with a parent education program becomes a reality. However, we found that as the program began to accomplish its goals the staff quickly gave us their support and encouragement.

Although the pre-program orientation has been discussed first ongoing education for the clinic staff is vital. To ignore the other staff members when providing an educational service to the community is short-sighted since the program dwells within the clinic, an equally important community. However, as one gets involved in providing service it is easy to forget about the education of the workers in adjacent units. Therefore, this element must be built into the program. The more information the clinic staff has about the program the more helpful they can be. They may come up with ideas to strengthen the service. In addition, because they also deal with the parents and the children they can refer clients who will benefit from the service.

B. Education of the community

How does one educate the community about an educational intervention program? For a start, in the open playroom it is natural to invite parents to come in to observe the children. If they stand by the partitions, go over and talk to them about what you are doing and why this might be of interest to them. In the separated playroom, it is necessary to go outside to meet parents. Outreach occurs naturally in the open playroom and it is one of the reasons we prefer it to the separated room.

There are continuous opportunities to teach parents how play leads to

learning, one only has to take advantage of them. For example, one parent was afraid to let her 2 1/2 year old daughter come into the play area. She explained that the child chased people around the house with a broom and hit them over the head. Nobody could stop her. Yet she observed this same child was occupied purposefully for an hour and did not interfere with anybody. Under these circumstances, it was natural to explain that we had picked out toys that met her abilities at her particular age. We then added that we carefully selected toys for the other children as well. As she could see, they were able to sit still and pay attention to the task at hand. This kind of information leads to other questions about proper play activities for the home as well as about the program for parents. Finally, observing other parents participating in the program proved to be the best advertisement. Volunteer participants reported that they checked with other parents whom they had seen working with the trainers and then approached a staff member about entering the program.

C. Utilization of program by other disciplines

Other disciplines used the playroom to make observations of the children's behavior in a naturalistic setting. This was especially helpful for children with possible developmental, behavioral and emotional disorders. The examining room tends to restrict normal behaviors that are important in making a differential diagnosis related to the problems mentioned above. The area can also be used to teach professionals about the kind of normal child behaviors that occur in a play setting as well as for the observation of parent-child interactions. Some of the disciplines represented were nursing students and graduate nurse trainees, medical students and pediatric house staff and clinical students in early childhood education.

VI. Extension of parent education program (EPEP) using a group format.

A. Rationale

At the parent request additional sessions were scheduled. A group format that maintained the educational focus was employed for the extension to the base program. Lombard (personal communication, 1972) has used group training as an adjunct to a home-based parent educational program in Israel. She said that this method adds to the knowledge base of the parents by encouraging them to explore other areas of child development including personality, independence, discipline, etc., in addition to adding to their experiences in cognitively oriented play activities. The more advanced activities taught in the EPEP led easily to related areas of child development. The group encourages discussion of methods of handling children on a variety of levels and permits parents to consider alternative modes used by other parents with children of the same age. The professional guides the flow of ideas and encourages the more timid parents to contribute to the discussion.

The group format would not have been viable for the initial program, for the following reasons: 1) parents had to learn to keep appointments; 2) a base of experiences and information is needed to participate effectively in the group.

B. Implementation

The group was made up of 6-8 English and/or Spanish speaking adults. Meetings were held once a month for one hour. The method of instruction was similar to that used in the individual trainer-parent sessions. The group was led by a professional and a bilingual paraprofessional who served as a translator as well as intervenor. The professional demonstrated the teaching method with

one parent while others observed. Parents were then assigned to teams of two, to work with one another using the demonstrated method. The project staff monitored and assisted when necessary.

A curriculum with a primary focus for each session, i.e., numbers, colors, etc.) was developed (see Appendix, page Books were used in conjunction with the game. The subject matter of the story was related to the selected activity. Initially, two toys were presented at each session. The games were similar due to the limited objectives of each exercise. Parents were given an opportunity to make their own selection. However, they consistently selected the same toy. After the first two meetings, we decided that the selection of one toy vis a vis another fragmented the discussion period. It was more economical, in terms of time available and goals, to use a single activity.

Worksheets with an outlined teaching guide were given out at the close of each session (see Appendix, pages). Parents were asked to answer questions about the child's performance and also about his ability to play with others. Prior to each session the worksheets were collected and discussed. Parents were asked to tell others how they related the previous game to everyday activities, e.g., Object Lotto led to naming kitchen and bathroom utensils, so they could learn from each other.

C. Results

Parents were initially skeptical about their children's abilities to handle more formal games, e.g., Candyland. Some reasons given were that the children could not follow rules, would not take turns and were to young too play cooperatively with other children. Their comments gave the group leader a

chance to explain that all of these abilities are learned and can be taught by using appropriately selected games. As parents saw their children handle these advanced activities with ease they began to look for similar games in local stores. They shared their finds with others in the group. We also found that after the target child learned the exercise, often, both parents and other siblings joined in. The introduction of games that appealed across ages, e.g., War, had led to a total family involvement.

When parents worked with on another they were much freer with their comments than when working with a staff member. We also found that they were more assertive in the group discussions. This may have been due to their increased expertise as well as a greater ease when associating with their peers. They responded enthusiastically to the social aspects of the group. However, our expectations that they would find others to serve as sources of support when the program ended were not fulfilled. They did not exchange addresses or telephone numbers. At the final session we discussed this with the parents. It was decided that the staff should have facilitated an exchange of information as part of the group experience rather than waiting for the parents to do so.

The evaluation of the group is tentative since there were only seven groups and these were started from 3-4 months after the party-meeting. However, we feel that we can make some statements about the use of the group format as an adjunct to individual training sessions. A summary follows:

1. The group format is an effective method of teaching parents with previous learning experiences how to carry out a home program. They can also learn how to select their own materials from the example set by other parents.

2. The group experience can lead to social linkages with other adults in the community. Parents served as advocates for educational institutions in the community, such as Head Start, and participated in community action groups.

3. Independence is encouraged in the group sessions. As parents talked with others in the community they learned about outside agencies, e.g., libraries, school programs, that can be used by members of their family.

4. General questions related to child rearing were raised more easily in a group setting. There were more opportunities to discuss the relationship of emotional and social growth to cognitive development.

5. Staff time was used more efficiently in the group.

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INTERVIEW FOR PARENT EDUCATION PROGRAM

Introduction:

We have a program in the playroom to show parents different ways to teach a young child at home. This program is for children from 20 to 39 months. It will help prepare your child for school. You will be asked to come to this playroom every 2-3 weeks for about six months. One of our staff members will how you show to use a toy to teach your child while playing with him. You will take the toy home and work with your child every day.

When you come to the clinic for this program you can bring your child with you. He can play here while you work with someone on new ways to teach him.

Questions:

Is your child between 20 and 39 months? (if no, excuse yourself and proceed to the next parent.)

Do you have time to work with your child for 15-20 minutes a day? (This question makes the parent aware that she will have a role in this program. Although the answer is usually yes, she can use this as an excuse if she wants to say no to the final question.)

Would you like to be in the program? (if answer is yes, fill out the Initial Contact With Parents form and give appointment for evaluation).

Explanation of Evaluation: *

We are interested in learning more about what the young children in East Harlem can do. We like to evaluate all the children before they start the program. You can come and watch us work with your child.

*Testing is optional. We found a brief explanation was preferred by the parents since this statement usually led to questions.

Mount Sinai Hospital
Department of Pediatrics

Parent Education Program

INITIAL CONTACT WITH PARENTS

1. Name of child _____ I.D.#..... _ _ _ _ _ _ 1-6

2. Today's date _ _/_ _/_ _ Birth date _ _/_ _/_ _ Age in mos..... _ _ 9-10

3. Sex: Male=1; Female=2 ..... _ 11

4. Birthplace _____ (NYC=1; South=2; Puerto Rico=3; Other=4)..... _ 12

5. Name of Hospital _____ Born in hospital: yes=1; no=0..... _ 13

6. Clinic # _ _ _ _ _ _ Telephone # _ _ _-_ _ _ _

7. Name of parent _____ Zip code: _ _ _ _ _

8. Name on mailbox _____ Address _____ Apt.# ____

9. Language: Parent _____ ....(Eng.=1; Span.=2; Other=3; Eng/Span.=4)... _ 14
Child _____ ..... _ 15
Home _____ ..... _ 16
Interview _____ ..... _ 17

10. Place of interview .....(Clinic=1; Emergency Rm.=2; WCHS=3; Telephone=4; OB=5; EHCHS=6)..... _ 18

11. Distance from institution: Walking=1; Less than ½ hr. public transportation=2; More than ½ hr. public transportation=3..... _ 19

12. Will you come in for the evaluation: Yes=1; No=0..... _ 20

13. Payment: ADC=1; Medicaid=2; Other=3..... _ 21

14. Birth order: 1st born=1; 2nd born=2; etc..... _ 22

15. Number of other children ..... _ _ 23-24

16.

Sex	Age in yrs.	Sex	Age in yrs.	(list oldest to youngest)	(Male=1 Female=2)	
___	___	___	___			25, 26-27
___	___	___	___			28, 29-30
___	___	___	___			31, 32-33
___	___	___	___			34, 35-36
___	___	___	___			37, 38-39

17. Kept evaluation appointment: Show=1; No show=0; Int./Eval. Simultaneous=3..... _ 42

18. Group assignment: Early=1; Later=2 ..... _ 43

19. Date of evaluation _ _/_ _/_ _

20. Age at time of evaluation (in months)..... _ _ 45-46

21. I.Q. score..... _ _ _ 47-50

22. Ethnicity: Spanish=1; Afro-American=2; Other=3..... _ 53

23. Sex: Male group=1; Female group=2..... _ 54

24. Appointment time _____ Place _____

Interviewer _____ (Comments on back)

MOUNT SINAI SCHOOL OF MEDICINE
of The City University of New York
FIFTH AVENUE AND 100TH STREET • NEW YORK, N.Y. 10029

Department of Pediatrics

Dear Mrs.

We are planning to start the Playroom Program for Parents next week. Your first appointment is _____,

_____ at _____.

If this is not convenient please call 876-1000, ext. 8942 and ask for _____.

Thank you for your patience. We look forward to seeing you.

Sincerely yours,

Anne G. Morris
Project Director

Mount Sinai Hospital
Parent Education Program

Location_____

FIRST APPOINTMENT RECORD

Name of child: _____

Name of parent: _____

Address: _____ Apt. #_____

Telephone #: _____ (if no telephone, write: no phone)

Exercise level: _____

FIRST APPOINTMENT: Date _____ Time_____

Appointment made by: (circle) telephone letter

Letter returned: (circle) no yes Reason: _____

Appointment kept: (circle) yes no

NEW APPOINTMENT GIVEN: Date _____ Time_____

Appointment made by: (circle) telephone letter

Appointment kept: (circle) yes no

POSTCARD AND LETTER SENT: Date_____ Postcard returned: (circle) yes no

COMMENTS: _____

_____

_____

_____

Name of trainer: _____ Date: _____

TRAINING SCHEDULE
PARENT EDUCATION PROGRAM

Mount Sinai Hospital
Department of Pediatrics

Trainer_____

Name of child_____Exercise level____Clinic# _ _ _ _ _ _ _

Name of parent_____Address_____

Language of parent: Spanish, English, Span/Eng. Telephone # _____

Books: English_____Spanish_____ Home visit: yes=1; no=0.....__

APPOINTMENTS

	1	2	3	4	5	6	7	8	9	10	11	12	
1. APPOINTMENT:*													
1. early													.....
2. on time													.....
3. late													.....
4. missed													.....
2. RETURNS EQUIPMENT													
1. complete													.....
2. incomplete													.....
3. not at all													.....
3. UNDERSTANDS EXERCISE													
1. one demonstration													.....
2. 2-3 demonstrations													.....
3. unclear as to how much understood													.....
4. INTEREST IN EXERCISE													
1. a lot													.....
2. medium													.....
3. a little													.....
4. none													.....
5. HOME CHECK LIST													
1. complete													.....
2. incomplete													.....
3. did not bring in													.....

* Appointments:
1. Attach appointment slip to record.
2. Record date of each appointment kept on top line.
3. Record date of missed appointments below.

MISSED APPOINTMENTS:

Child's name_____ Clinic number: __ __ __ __ __ __

ITIAL IMPRESSION: (Note appearance of child and parent; parent's response to training session, attitude towards child, trainer, hospital, etc.)

RECORD OF LETTERS AND TELEPHONE CALLS BEFORE APPOINTMENT

INTERIM NOTES

Child's name_____ Clinic number: _ _ _ _ _ _ _

INTERIM NOTES Continued:

FINAL IMPRESSION:

Parent Education Program _____ Location: MSH LHCMS (circle)

APPT. TIME	TRAINER	NAME	EXERCISE LEVEL	EXERCISE NUMBER	KEPT APPT.	DATE OF NEXT APPOINTMENT
9:00						
10:00						
11:00						
12:00						
1:00						
2:00						

Mount Sinai Hospital
Department of Pediatrics

Parent Education Program
Date _____

OBSERVATION OF TRAINING: PARENT AND CHILD, LESSON #3

Name of child_____ I.D. # ... 1 2 3 4 5 6

Location: Mount Sinai Hospital = 1; East Harlem Child Health Station=2;..... 7

CHECK ONE:

1. Parent's method of handling child: permissive=1; average=2; authoritarian=3..... 8

2. Parent's attitude: disinterested=1; average=2; overconcerned=3..... 9

3. Attitude of child toward parent: uncooperative=1; overly attached=2 affectionate and responsive=3..... 10

4. Response of child toward trainer: normally responsive=1; shy and close to parent=2; very demanding=3..... 11

5. Follows training method: yes=1; no=2; yes with adaptation=3..... 12

6. Parent's response during training: praises child when appropriate=1; too much praise=2; no praise=3..... 13

COMMENTS:_____

INTERVIEW FORM: FINAL EVALUATION OF TRAINING PROGRAM BY PARENT

Name_____ Date_____

1. Why did you start the program?

2. Would you do the training with another child?

   Why?

3. How did the program affect your child?

4. How do you feel about the teaching methods used with the toys?

5. What problems did you have with the teaching methods?

6. How do you think the program can be improved?

7. What is the best way to tell parents about our program?

8. When you missed appointments what is the best way for us to tell you about them:

   Letter with new appointment_____ Telephone call_____

   Do you mind being called when you miss an appointment_____

9. General comments:

Trainer_____

EAST HARLEM CHILD HEALTH STATION

CONGRATULATIONS

AND

ON COMPLETION OF THE

PARENT EDUCATION PROGRAM

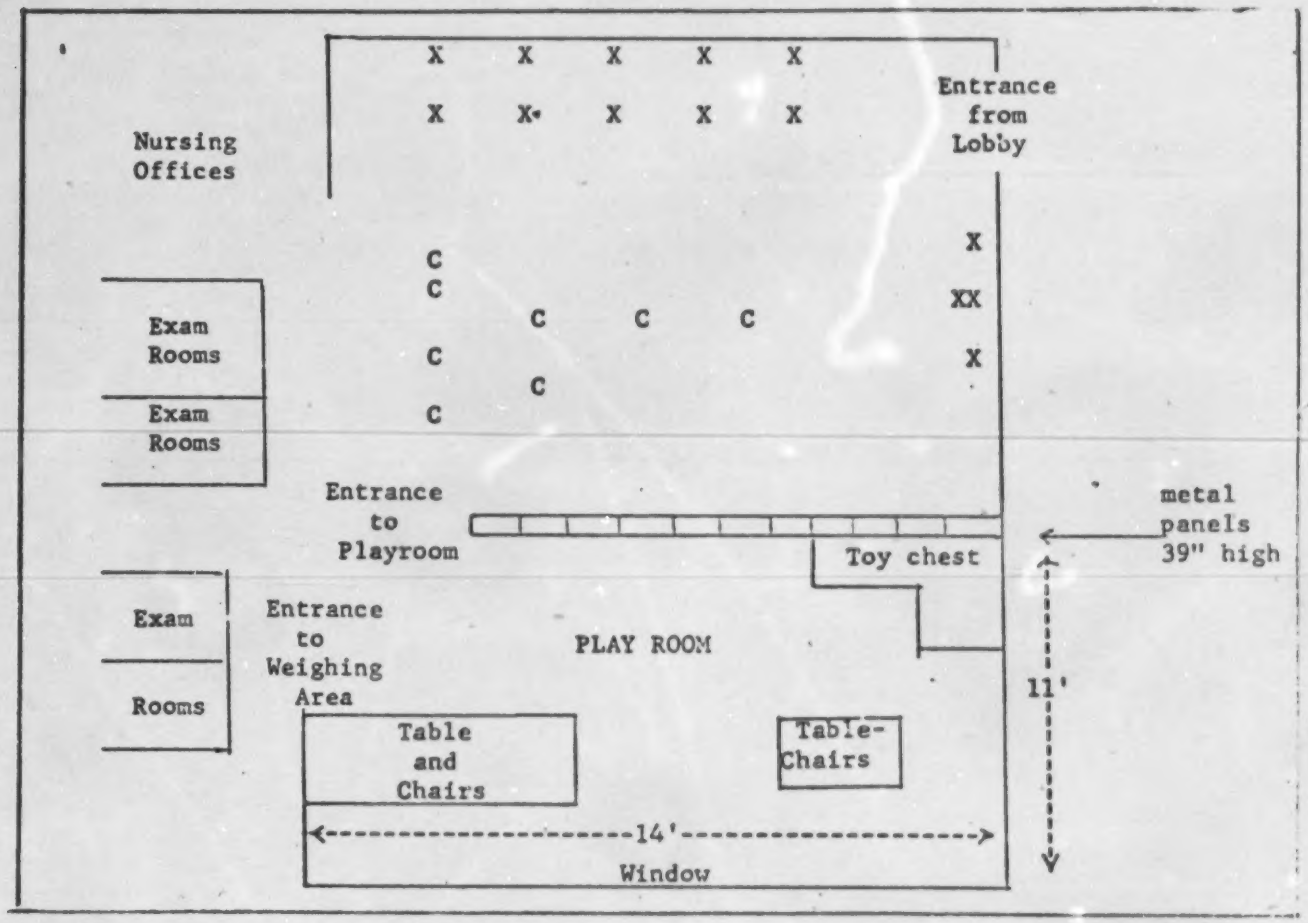
INSTRUCTOR

PROGRAM DIRECTOR

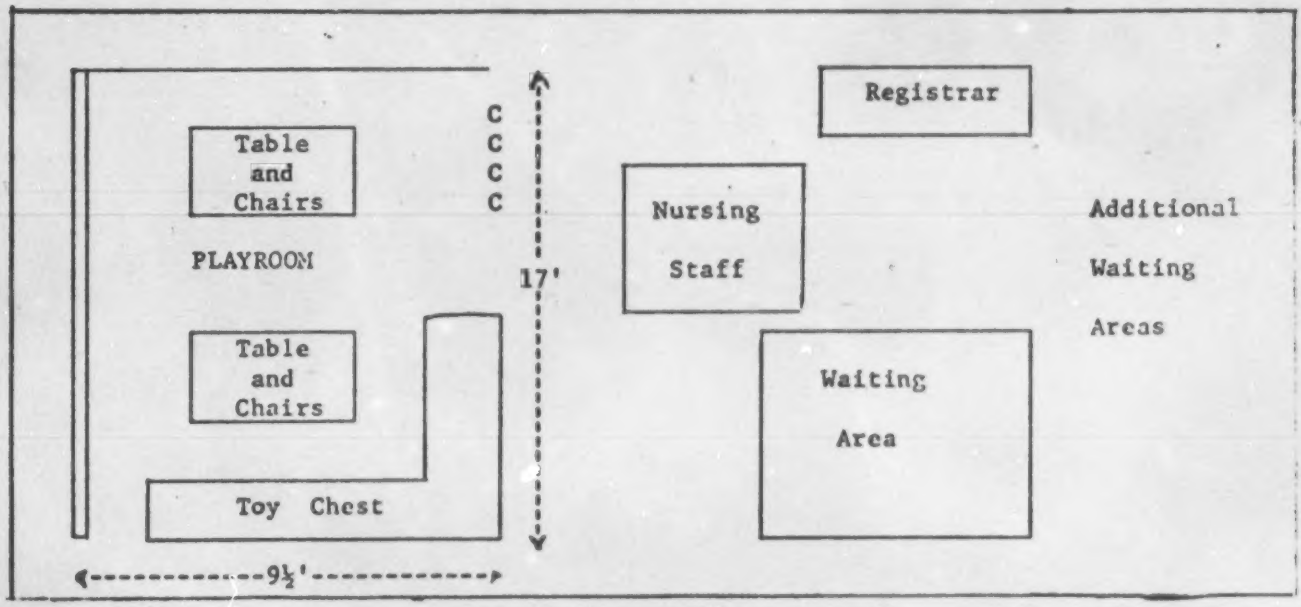
OPEN PLAY AREAS

Key: X - chairs for waiting parents
C - clerical areas

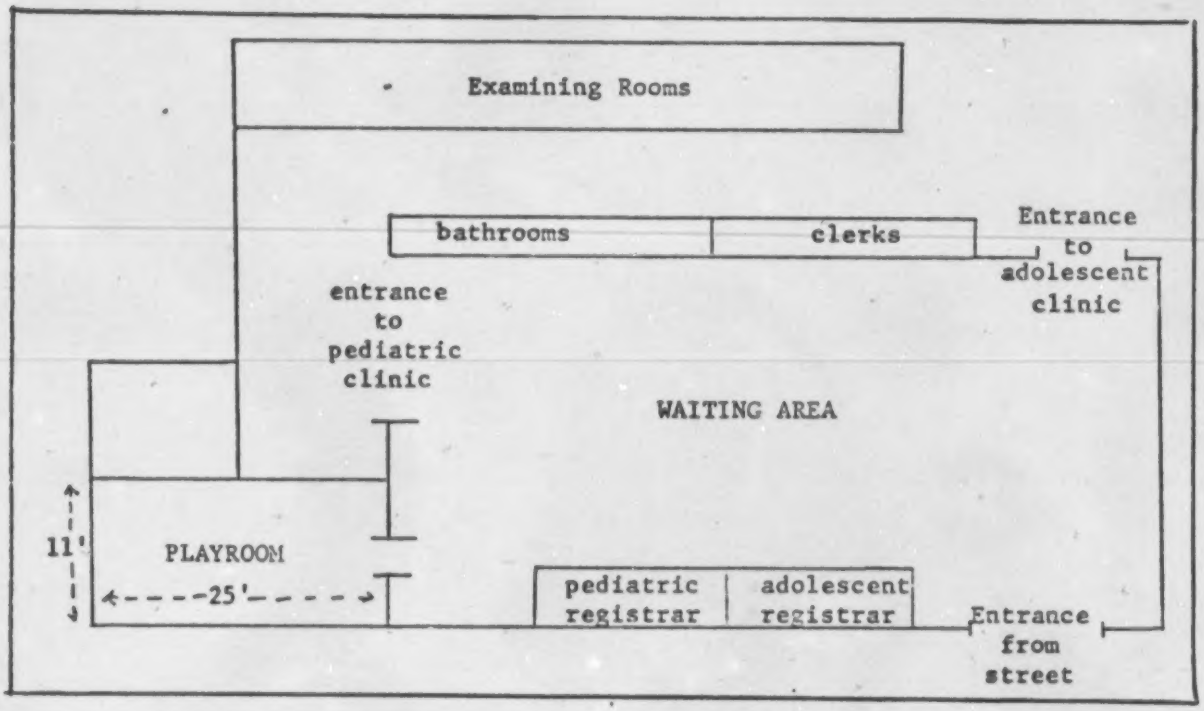
East Harlem Child Health Station



Prenatal Clinic of the Mount Sinai Hospital



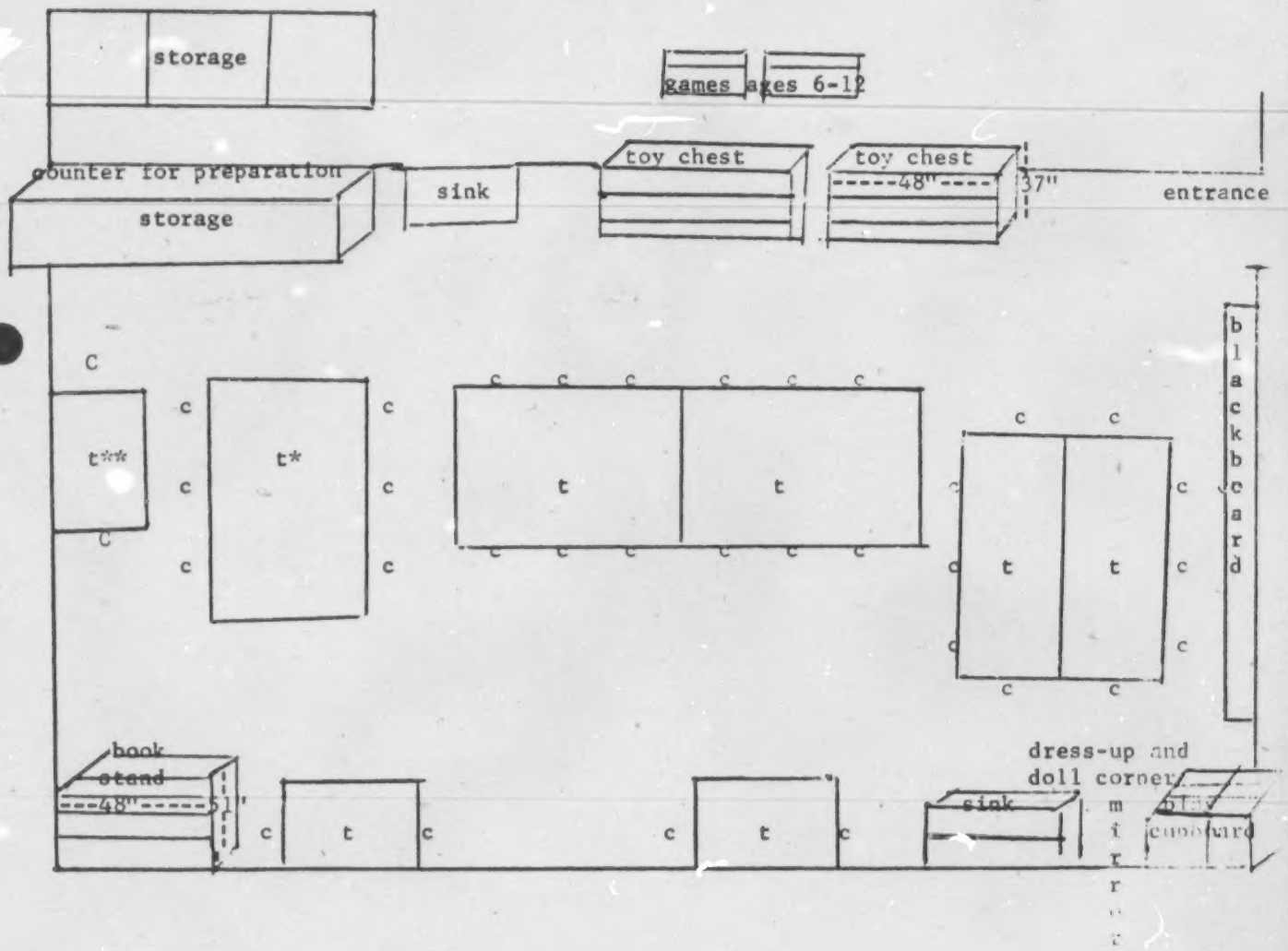
SEPARATE PLAYROOM



DETAILS OF PHYSICAL LAYOUT OF SEPARATE PLAYROOM +

Key: C - adult size chairs
c - child size chairs
t**- table used only for parent education
t*- table used for play program and parent education
t - table used for play program

+ - All furnishings are standard nursery/playroom equipment and are available from suppliers of preschool and nursery programs.



MATERIALS USED IN PEDIATRIC PLAYROOM

Games	Cost *
Spirograph (Kenner)	$4.00
Spirotot (Kenner)	2.25
Battleship (Milton Bradley)	4.00
Candyland (Milton Bradley)	1.95
Chutes and Ladders (Milton Bradley)	2.00
Scrabble for Juniors (Sechow and Righter)	2.75
Parcheesi (Sechow and Righter)	3.00
Hi-Ho Cherry-O (Whitman)	1.29
Tip-It (Ideal)	3.00
Headache (Kohner)	2.00
Checkers	.69
Chess	.69
Manipulative Toys	
Threading Block (Childcraft)	3.95
Plastic puzzle blocks (Woolworth's)	1.95
Ji Gantiks	2.95
Play Chips (Playskool)	4.50
Form Board (Playskool)	2.75
Fit-A-Size (Lauri Enterprises)	4.00
Snap-Lock Beads (Fisher-Price)	1.25
Quercetti-Coloredo Pegs (Quercetti, Turin, Italy)	.60
Double Track Shapees (Kohner)	2.25
Looney Links (Kohner)	2.25
Bill Ding Wooden Men (Playskool)	4.20
Locking Blocks (Kenner)	4.50
Toycraft (Childcraft)	4.75
Snap-N-Play (Sifo)	3.50
Wooden Blocks (Heros, West Germany)	2.50
Playphone	1.00
Bell and Rings (Playskool)	2.90
Hourglass (Playskool)	2.70
Postal Office (Playskool)	4.50
Beaufix (West Germany)	6.00
Plastic blocks (Woolworth's)	.89
Nail-On-Tiles (Spears)	2.50
Color Links (Childcraft)	2.50
Ringa-Majigs (Childcraft)	3.00
Col-o-rol Wagon (Playskool)	3.75
Lego Building Toy (Lego)	5.00
Puzzles	
Judy puzzles (wooden)	2.95
Whitman cardboard puzzle	.39
Whitman frame tray puzzle	.69
Accessory toys and supplies	
Paper dolls	1.30
Coloring books	.39
Crayons	1.60/gross
Magic markers	1.60
Manila paper	1.80/ream

MATERIALS USED IN PEDIATRIC PLAYROOM con'd.

	Cost*
Blackboard	**
Chalk (Imperial Crayon Co., Bklyn, N.Y.)	2.25/½gross
Blackboard eraser	1.50
Hats	1.40
Pockets books, dress up clothes and shoes	**
Play dishes	2.95
Small play dolls	1.50
Hand puppets (Novo, washable)	2.00
Books	**
Woven rattan trays, approximately 10"x13". One for each toy placed upon the open shelves. Available at Azuma in New York City or stores selling Japanese housewares and novelties.	2.50

* Costs are approximate

**Prices on these items are related to space in terms of blackboard size, or possibility of donations in regard to books and dress up items.

PLAYROOM PROCEDURES

1. Greet all children who come into the playroom as follows:
   a. Ask for name and age, write on tape and attach to clothing. If the child is young ask the parent for this information.
   b. Show the child the toys and explain that he can choose the one he likes, but when he has finished with it it must be returned to the toy shelf before he takes another.
   c. When a child is not able to master a toy the staff member should show him how it works. If he still cannot handle it after an explanation the staff member should help him to pick out a substitute that is more suitable.

      Groups of children who are playing games may need help with the rules.

2. Recruitmant of children from the waiting area:
   a. Often it is necessary to go out to the parent and explain that the child is welcome to come into the play area. You may also invite the parent to join him in the playroom if she cares to do so.
   b. In the child health station it is also necessary to go into the area where the children are weighed before examination and tell the parents that the children can come into the play area while waiting to see the doctor.

3. Leaving the playroom for the examination or home:
   Assist the parent who has difficulty in getting the child to leave. If the child is crying, explain that this happens frequently and that he will stop after he leaves the area. This is a normal response of young children and the parent should be reassured that her child is behaving in an acceptable fashion.
   Sometimes it helps if the staff member lifts the child for the parent and removes him from the area. Often the child's behavior is embarrassing for the parent and she will appreciate assistance from the staff.

4. Serving nourishment:
   Milk or juice and cookies are stored in the kitchen. They are provided for the children waiting in the playroom. Serve refreshments early in the session, both morning and afternoon. In order to get to the clinic on time they may have missed breakfast or lunch.
   An announcement should be made in both Spanish and English that "milk and cookies" are being served and the children should be asked to remain seated until everyone has been served. Ask the children to eat immediately after being served and to stop playing while they are eating. This will prevent spilling and since there is a limited amount of food there may be no opportunity for a second cup.
   It is best when serving to fill one tray with drinks and the other with cookies. Older children enjoy helping and should be encouraged to do so; they can easily pass the cookies.

5. How to handle disruptive and hyperactive children:
   a. Ask the parent for suggestions on how to handle the child and if necessary ask her to stay in the play area.
   b. Isolate the child so that he will not disturb the other children and in turn will not become overstimulated by the play activities. The bookcase can be pulled out and a table placed behind it. Explain that the child may stay in the playroom but that since it is difficult for him to play in a crowded room this is a special place where he can work undisturbed.

PLAYROOM PROCEDURES con'd.

c. Report behavior observations on the referral form so that it can be put into the child's chart. It is important for the medical staff to know about the playroom activities of the disruptive child since the child may behave differently during the medical examination.
Disruptive and damaged children require special training early in life. There are educational programs designed especially for these children. The observations and comments of the staff will help the doctor to refer the child at the proper time.

Games to teach colors:

Balloon Game:

1. Each player is given a playing board.

2. Balloons are placed on the table in front of the players.

3. Each player is assigned a turn.

4. The first player rolls the dice and picks out the balloon that matches the color on the dice and puts it on the matching balloon on his board. If the balloon does not match a color on his board he puts it back on the table.

5. The next player takes his turn.

6. The first player to fill all the spaces on his board wins the game.

Candy Land:

1. Each player chooses a different colored playing piece.

2. All pieces are placed at "Start."

3. Each player is assigned a turn.

4. The first player takes a card and moves it to the space matching the picture. The cards with pictures are at different places on the board and the child may need help to find the proper place.
If the card has two colored squares the player may move

5. To reach HOME a player must land on the last blue space or take a card that would go beyond the last blue space. The first player to reach HOME wins the game.

Two or more players may occupy the same space.

Winnie the Pooh:

1-2-3 As above.

4. Discs are put into the bag and the first player reaches into the Grab Bag and without looking pulls out one disc. He moves his piece to the first square that matches the color of the disc.

5. When a player lands on special spaces he must follow the instructions. Since the child cannot read the parent must explain the directions to him.

6. To reach the North Pole the player must draw a red or blue disc, if he does not do so he must give up his turn to the next person. The first person to reach the North Pole wins.

EXTENDED PARENT EDUCATION PROGRAM CURRICULUM

CARD GAMES*

War game (Prepare the cards as follows before your start playing. Take 2 each of cards 1(ace) through 6, a total of 12 cards. Use only one color to start.)

THIS GAME IS CALLED WAR.
EACH CARD HAS A NUMBER ON IT AND ALSO A CLUB(SPADE) THAT MATCHES THE NUMBER.
LET'S GO THROUGH ALL THE CARDS.
CAN YOU TELL ME THE NUMBER OF CLUBS (SPADES) ON EACH CARD?
If the child can do this, start the game.

I AM GOING TO MIX UP THE CARDS AND GIVE ONE TO YOU AND ONE TO ME SO WE BOTH HAVE THE SAME NUMBER OF CARDS.
THE CARDS ARE TURNED OVER SO YOU CANNOT SEE THE NUMBERS.
TAKE THE TOP CARD OFF THE DECK AND TURN IT OVER LIKE THIS.
Each person puts a card, face up, on the table.
THE PERSON WITH THE HIGHEST CARD GETS BOTH CARDS.
Keep playing until one person gets all the cards.

Increase by one number each time you play, if the child can handle it. It may not be possible to use the picture cards until the child is older, but this varies from one child to another.

Concentration (Select 4 sets of cards, a total of 8 cards. It is best to have the colors the same in each set, e.g. black 3's, red 4's, black 5's, and red 6's, as this will serve as another clue.)

THIS GAME IS CALLED CONCENTRATION.
FIRST, LET'S PUT ALL THE CARDS IN ROWS (face up) AND SEE IF YOU CAN MATCH THEM.

— —
— —
— —
— —

Help the child to match each card to its mate, so he gets the idea of the game. Be sure to point out both the number and the suite. If it helps mention the color of the suite as well.

NOW I AM GOING TO MIX UP THE CARDS.
I WILL PUT THEM FACE DOWN ON THE TABLE IN ROWS (as above).
LET ME START AND SHOW YOU HOW TO PLAY.
Turn over 2 cards, if they match, take them off the table. Turn over two more until the cards do not match. The other person now takes his turn.
Be sure to turn the cards over fully before you turn them face down so the child can see them. Point out that he should remember where they are so he can find them when it is his turn to play.
The person with the most cards wins the game.

Increase by one set each time you play if the child can handle it. This game is more difficult than WAR since it demands complete attention and the ability to remember where the cards are placed.

*These games were planned for children aged 4 years.

Hi-Ho Cherry-O

1. This is a game called Hi-Ho Cherry-O.
2. Each player picks a cup and then puts cherries in the tree with the same color as the cup at the bottom.

   "What color do you want?"

   "I will take_____."
3. Put cherries in the tree.
4. The winner is the first one to put all the cherries in the cup.

   Now how do you decide how many cherries to take off of the tree?
5. This is the spinner and when you turn it like this (demonstrate) you will see how many cherries to take off the tree.

   Let me show you. (Explain each section)

- Object Lotto/Zoo Lotto (Select 12 cards that match pictures and 4 that do not match)

This game is called Object (Zoo) Lotto.

Each player gets one board. There are six pictures on each board.

There are single cards with pictures that match the objects on each board. The first person to put all the matching cards on his board wins the game. I will mix up these cards and then turn them so the pictures face down.

You can go first. Take the card off the top. "What do you call this?"(if child cannot name, say it for him and ask him to repeat it).

"Does it match a picture on your card?"

If yes, "Put the card on top of the picture?"

If no, "Put the card on the table with the picture facing down."

When you finish the game exchange cards so that the child will learn the names of the objects on the other board.

If he can name four out of six objects on each board, go onto next two boards.

Return to other boards continuing with two cards at a time until child can name all the objects.

Tinker Toy

This is a tinker-toy. You can make different models with it.

First I want to show you all the parts and then we can build something.

This is a spool - it is round - it has a hole in the center and holes all around the sides. The rods go into the holes. Find me some more spools. Put them all into one pile.

This is a wheel. It has only one hole in the center. There are three more wheels. Find them and you can put the wheels in a pile too.

These are the rods. They come in four different sizes and four different colors.

Look, the orange rod is the shortest. The yellow rod in a little longer than the orange rod. The blue rod is a little longer than the yellow rod. The red rod is the longest of all. Now you do the same thing with the rods that you did with the spools and wheels. Put the rods that are the same color and same size into a pile.

The other parts are on page two of the booklet:

B - point
U - rod cap
L - bearing
pp - plastic pennant
WB - wind blade

Let's find them so you can be prepared to tell about them.

You can name these parts to your child as you use them. The other parts are shapes and colors we have worked with earlier and your child should know them all.

Before we start putting models together you should try to put the rosa into the holes and loosen them up. This will make it easier for your child whose hands are not as strong as yours.

Turn the rods to get them in and out of the holes, or the points will break.

Name of child_____Date of meeting_____

Toy: Balloon Game/ Candy Land Teaches: Colors

First Week:

Play game with parent only: Yes___No___

Follows rules of game: Yes___No___

Knows colors: Yes___No___

Comments:_____

_____

Second Week:

Plays game with one other person and parent: Yes___No___

Plays game with parent only: Yes___No___

Follows rules of game: Yes___No___

Comments:_____

_____

Third Week:

Plays game with one other person: Yes___No___

Plays game with one other person and parent: Yes___No___

Plays game with parent only: Yes___No___

Follows rules of game: Yes___No___

Comments:_____

_____

Fourth Week:

Plays game with other children: Yes___No___

Plans game with one other person: Yes___No___

Plays game with one other person and parent: Yes___No___

Plays game with parent only: Yes___No___

Comments:_____

_____

Finds matching colors of objects in home: Yes___No___

Name of child_____ Date_____

Title of book_____ Teaches_____

How often do you show the book to the child: Daily _____ Once a week _____
Twice a week _____
Other (explain) _____

_____

When do you use the book: After the training _____ at bedtime _____
Other (explain) _____

Please comment on the book; feel free to say what you think about it and how your child feels about it:

_____

_____

_____

_____

Name of Child: _____ Date: _____

Game Selected: Hi Ho Cheerio (playing cards optional) Teaches: _____

Plays game with parent only Yes _____ No _____

Follows rules of game Yes _____ No _____

Knows numbers in game Yes _____ No _____

Comments: _____

_____

_____

Can proceed to 1st 6 numbers of War Game:

Knows numbers from 1 (ace) to 6 Yes_____ No _____

Does he understand game? Yes_____ No _____

How long did it take the child to learn the rules?_____

_____

Name of Child:_____ Date of Meeting:_____

Game Selected: Card games Teaches: numbers

War Game

Knows numbers from 1 (ace) to 6: Yes___ No___

Knows numbers from 1 to 10: Yes___ No___

Knows numbers from 1 to king: Yes___ No___

Does he understand game? Yes___ No___

How long did it take the child to learn the rules?_____

_____

Concentration

Understands game by the end of the first week_____second week_____third week_____

fourth week_____

Does not understand how to play game_____

Child is able to play with 4 sets of cards (8) Yes ____ No ____

Child is able to play with 5 sets of cards (10) Yes ____ No ____

Child is able to play with 6 sets of cards (12) Yes ____ No ____

Plays game with parent only Yes ____ No ____

Plays game with one other person and parent Yes ____ No ____

Plays game with one other person Yes ____ No ____

Comments: _____

_____

_____

Name of child: _____ Date: _____

Game: LOTTO Teaches: Object labeling

Plays game with parent only Yes _____ No _____

Plays game with parent and others Yes _____ No _____

Understands rules of game Yes _____ No _____
sometimes _____

Can name and match all objects on cards 1-6 Yes _____ No _____

Can name and match all objects on cards 7-12 Yes _____ No _____

Can name and match all objects on cards 13-18 Yes _____ No _____

Can name and match all objects on cards 19-24 Yes _____ No _____

Can name and match all objects on cards 25-30 Yes _____ No _____

Can name and match all objects on cards 31-36 Yes _____ No _____

If no, what objects is child unable to name or match:

Cards 1-6 _____

Cards 7-12 _____

Cards 13-18 _____

Cards 19-24 _____

Cards 25-30 _____

Cards 31-36 _____

COMMENTS: _____

_____

Finding objects in magazines, newspapers and books:

Can child find and name objects: Yes _____ No _____

Does child cut out and paste objects Yes _____ No _____

Does child circle pictures: Yes _____ No _____

Does child color pictures with crayons Yes _____ No _____

COMMENTS: _____

_____

Name of child: _____ Date _____

Game: TINKER TOY Teaches: _____

Can he separate the spools for the wheels: Yes ____ No ____

Can he arrange the rods by color: Yes ____ No ____

Can he name all five colors: Yes ____ No ____

If not, what colors can he name? _____

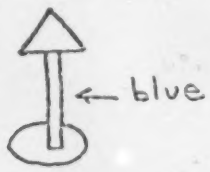
Can he understand size differences: Yes ____ No ____

Can he put the rods in the holes: Yes ____ No ____

He follows instructions and can make the following models by himself: Yes ____ No ____

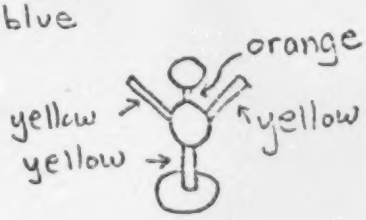
with help from his mother: Yes ____ No ____

TREE



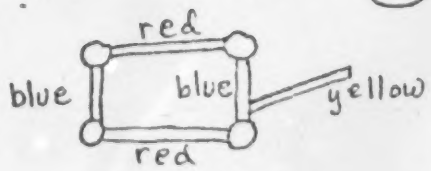
Yes ____ No ____

ROBOT



Yes ____ No ____

WAGON



Yes ____ No ____

Made up own models and put them together with help: Yes ____ No ____

Learned to put together more complicated models with the help of the parent: Yes ____ No ____

Plays with tinker toy and allows another child to share it with him: Yes ____ No ____

Always needs parent to help him with toy: Yes ____ No ____

COMMENTS: _____